



Department of Medical Assistance Services
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Richmond, Virginia 23219

www.dmas.virginia.gov

MEDICAID MEMO

TO: All Intensive In Home Providers, and Managed Care
Organizations Participating in the Virginia Medical
Assistance Programs.

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services

MEMO: Special

DATE: 5/30/2008

SUBJECT: Changes to the Prior Authorization Process for Intensive In-Home Services – Effective
July 1, 2008

The purpose of this memorandum is to provide information on changes to the Intensive In-Home (IIH) program and prior authorization (PA) process with Virginia Medicaid's PA contractor, Keystone Peer Review Organization (KePRO). The two changes include (1) a separate procedure code for assessments and (2) prior authorizations will be required after the first 12 weeks of service.

To support these new requirements, a WebEx training will be held June 19, 2008 from 3p.m. to 4p.m. to provide instructions on how to submit requests through KePRO. To log on to this WebEx, go to www.genesys.com and click on "join a meeting as a participant". Enter the meeting number: *9240330*, then choose "*How to submit a successful PA for Intensive In-Home Services*". The call-in number is 1-866-462-0164. This WebEx will be recorded and available on the KePRO website after June 19, 2008 to view at your convenience.

Changes to the IIH Program

Assessments (H0031)

Assessments performed on or after July 1, 2008 must be billed using the procedure code **H0031 (Intensive In-Home Assessment)**. A limit of two assessments per recipient may be reimbursed per fiscal year. A fiscal year is defined as July 1st through June 30th. The reimbursement rate is \$70 per assessment and do not require PA.

Services Provided after the Initial Assessment (H2012)

Effective July 1, 2008, the current authorization process will change from requiring authorization after the first 26 weeks each treatment year to requiring authorization after the first 12 weeks in the first year of treatment. The first year of service will commence July 1, 2008 for all individuals.

Individuals that were receiving IHH services either under State Plan Option or under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program that currently have an authorized period have been included in the new requirement. An existing authorization period or extension request that continues beyond July 1, 2008 will now be end dated June 30, 2008. Individuals currently under treatment will receive the first 12 weeks beginning July 1, 2008 without PA.

For service dates starting on or after July 1, 2008, the first 12 weeks do not require PA. All subsequent requests, regardless of the dates of services, will require PA through KePRO. The State Plan for Intensive In-Home Services allows 26 weeks of treatment per recipient. If a child under 21 years of age requires services beyond 26 weeks, coverage through EPSDT may be requested through KePRO. After the initial 12 weeks of treatment without PA, in the first treatment year, all weeks must be prior authorized. The first 26 weeks in subsequent treatment years are State Plan services, and any additional weeks are EPSDT services. Regardless of when services start for the first treatment year, the subsequent year's anniversary date re-sets to July 1. All treatment sessions for subsequent years require PA.

For reimbursement of this service, the individual must require 3 - 10 hours of therapeutic intervention per week. In exceptional circumstances, and with appropriate supporting documentation that includes medical necessity, providers may perform up to 15 hours per week, however this should not be routine. KePRO will authorize up to 50 hours per month once it is determined medical necessity has been met. Providers may only bill for the actual services provided, and this must be well documented, as stipulated in the *Community Mental Health Rehabilitative Services Manual*.

Providers will begin receiving their official authorization determinations (denials or approvals) via the First Health automated letter generation process. The letter generated from First Health will include a PA number. This number must be used when submitting claims. Claims submitted for services that exceed the units authorized, or exceed 50 units per month will be denied.

PA decisions will be made utilizing DMAS criteria identified in the *Community Mental Health Rehabilitative Services Manual*. Please refer to this manual for more detailed information regarding IHH services and billing requirements. The link is <http://websrvr.dmas.virginia.gov/manuals/CMHS/cmhrs.htm>.

Prior Authorization Process Through KePRO – Effective July 1, 2008

KePRO will accept requests for PA via iEXCHANGE (direct data entry through the web), fax, mail, or phone. The preferred method of submission for requesting PA is through iEXCHANGE

You must have a provider web account before submitting information through iEXCHANGE. To register for a web account, you must know your NPI and tax identification number. You will receive a log on pass code within 10 days of registration. To submit requests via iEXCHANGE, log on to DMAS.KePRO.org and register for a provider web account.

Submit requests for dates of service on and after July 1, 2008 via phone, fax, or mail to:

KePRO

Toll Free Phone: 1-888-VAPAUTH (1-888-827-2884)

Local Phone: (804) 622-8900

Fax: 1-877-OKBYFAX (1-877-652-9329)

2810 N. Parham Road, Suite 305

Richmond, VA 23294

To submit requests by fax or mail you must complete the request on the DMAS 366 (Intensive In-Home Service Request form and instructions), which is attached to this memo. This form and its instructions identify critical information to process IIH PA requests (i.e., whether received by web, fax, phone, or paper). The DMAS 366 form has been revised and is attached to this memorandum. It is also available under “forms” on KePRO’s website at <http://dmas.kepro.org> or at www.dmas.virginia.gov/pr-prior-authorization.htm.

When requesting PA through KePRO, **use procedure code H2012** (Intensive In-Home Services) and submit the request on the revised DMAS-366 (Intensive In-Home Service Prior Authorization Request form and instructions). The required elements for requesting authorization for service remain the same. Please review the revised fax form (DMAS 366) and instruction sheet attached to this memo.

KePRO will pend requests that require additional information in order to make a final determination. Notifications of pended requests will be sent back to the provider by fax. Providers are required to respond to KePRO’s request for additional information as quickly as possible to continue processing the request. The provider has three business days to provide the additional information or the request will be denied.

Resource Information

Should you have any questions regarding the prior authorization process, please send your inquiries via e-mail to providerissues@kepro.org or PAUR06@dmas.virginia.gov.

For questions specifically regarding any of the Community Mental Health Rehab Services, you may send inquiries to CMHRS@dmass.virginia.gov. Remember do not send Protected Health Information (PHI) by e-mail unless it is sent via a secure encrypted e-mail submission.

All other Medicaid provider issues not related to prior authorization should be addressed through the Provider Helpline. The numbers are 1-800-552-8627, or if you are located in Richmond or out-of-state, call 804-786-6273.

Alternate Methods to Obtain PA, Eligibility and Claims Status Information

DMAS offers an enhanced web-based Internet option Automated Response System (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is <http://virginia.fhsc.com>. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access prior authorization information including status via iEXCHANGE at <http://dmass.kepro.org/>.

Copies of Manuals

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at www.dmass.virginia.gov. Refer to the "DMAS Content Menu" column on the left-hand side of the DMAS web page for the "Provider Services" link, which takes you to the "Manuals, Memos and Communications" link. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates that are requested.

Provider E-Newsletter Sign-Up

DMAS is pleased to inform providers about the creation of a new Provider E-Newsletter. The intent of this electronic newsletter is to inform, communicate, and share important program information with providers. Covered topics will include changes in claims processing, common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at: www.dmass.virginia.gov/pr-enewsletter.asp. Please note that the Provider E-Newsletter is not intended to take the place of Medicaid Memos, Medicaid Provider Manuals, or any other official correspondence from DMAS.



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Intensive In-Home Prior Authorization Request Form

KePRO & DMAS now require that any Medicaid Provider submitting Prior Authorization Requests using their National Provider Identifier (NPI) or Atypical Provider Identifier (API) to provide a 9 digit Zip code. If you do not know your 9 digit Zip code, please visit <http://zip4.usps.com/zip4/welcome.jsp>

Fax: 1-877-OKBYFAX (877-652-9329) Phone: 1-888-827-2884

| <input type="checkbox"/> Initial Request <input type="checkbox"/> Extension <input type="checkbox"/> Retro Authorization Request <input type="checkbox"/> Transfer | | | | | | | | | | | | | | | | | | | |
|--|--|---|---|--------------------|--------|-----------|------------|--|--|--|---|--|--|--|---|--|--|--|---|
| 1) Admission Date: | 2) Enrollee Last Name: | 3) Enrollee First Name: | 4) Enrollee Medicaid Number: | | | | | | | | | | | | | | | | |
| 5) Requested Start Date: | 6) Date of Birth (mm/dd/yyyy): | 7) Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | 8) Provider Contact Person: | | | | | | | | | | | | | | | | |
| 9) Provider Name: | 11) Provider Address (including 9 digit Zip Code): | | 12) Provider Phone Number: | | | | | | | | | | | | | | | | |
| 10) Provider NPI/API #: | | | 13) Provider Fax Number: | | | | | | | | | | | | | | | | |
| 14) DSM IV DIAGNOSTIC CODES: (* Required) Axis I * _____ Axis II * _____ Axis III _____ Axis IV _____ Axis V (GAF): Current: _____ Highest in last year: _____ | | 15) CURRENT MEDICATIONS: <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"><thead><tr><th style="width: 40%;">Name of Medication</th><th style="width: 15%;">Dosage</th><th style="width: 15%;">Frequency</th><th style="width: 30%;">Compliant?</th></tr></thead><tbody><tr><td> </td><td> </td><td> </td><td>Y <input type="checkbox"/> N <input type="checkbox"/></td></tr><tr><td> </td><td> </td><td> </td><td>Y <input type="checkbox"/> N <input type="checkbox"/></td></tr><tr><td> </td><td> </td><td> </td><td>Y <input type="checkbox"/> N <input type="checkbox"/></td></tr></tbody></table> | | Name of Medication | Dosage | Frequency | Compliant? | | | | Y <input type="checkbox"/> N <input type="checkbox"/> | | | | Y <input type="checkbox"/> N <input type="checkbox"/> | | | | Y <input type="checkbox"/> N <input type="checkbox"/> |
| Name of Medication | Dosage | Frequency | Compliant? | | | | | | | | | | | | | | | | |
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| | | |
|---|---|---|
| 16) Enrollee Last Name: | 17) Enrollee First Name: | 18) Enrollee Medicaid Number: |
| 19) Current Symptoms/Behaviors : <i>For the initial review, please provide a narrative of the behaviors exhibited in major life activities by the client over the past 30 days that warrant the requested level of care (identify frequency, intensity and duration of each behavior). For continued stay this information should come from the most current 30 day progress report. (Identify frequency, intensity and duration of each behavior, and progress/lack of progress towards treatment goals).</i> | | |
| 20) Projected Discharge Date: | 21) Face-to-Face Assessment completed? (For Initial review only) Yes <input type="checkbox"/> No <input type="checkbox"/> Date of assessment: | 22) Individual Service Plan (ISP) completed within 30 days of the initiation of services? Yes <input type="checkbox"/> No <input type="checkbox"/> Date of ISP: ISP has dated signature of Qualified Mental Health Provider? (For first Extension request) Yes <input type="checkbox"/> No <input type="checkbox"/> |

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INTENSIVE IN-HOME SERVICES ELECTRONIC FAX FORM INSTRUCTIONS

Web Resources: www.dmas.kepro.org
 www.dmas.virginia.gov

This FAX submission form is required for **INTENSIVE IN-HOME SERVICES** prior authorization review.

Please ensure that all required information blocks contain the requested information. Incomplete forms may result in the case being rejected or returned via fax for additional information.

If KePRO determines that your request meets appropriate review guidelines, the request will be “tentatively approved” and transmitted to First Health Services (FHS) for final approval. Final approval is contingent upon passing remaining enrollee and provider eligibility/enrollment edits. The prior authorization (PA) number provided by FHS will be sent to you through the normal letter notification process and will be available to you via the web-based program iEXCHANGE (<http://dmas.kepro.org>) within 24 hours of the decision.

The following will guide you through the sections of the form

- Please mark with an **X** the type of request (Initial, Extension, Retro Authorization, or Transfer)
Transfer – Need last date of service from previous facility and start of care date at your facility

1. Admission Date

- Enter the date the recipient was originally admitted to the service

2. Enrollee Last Name

- Enter the enrollee’s last name exactly as it appears on the Medicaid card

3. Enrollee First Name

- Enter the enrollee’s first name exactly as it appears on the Medicaid card

4. Enrollee Medicaid ID Number

- Please ensure that the enrollee’s Medicaid number is valid and contains 12 digits (*This is the Provider’s responsibility*)

5. Requested Start Date

- Enter the date the requested services are to begin

6. Date of Birth

- Enter the date of birth in the MM / DD / YYYY format (for example, 02/25/2008).



7. Gender

- Please mark with an **X** the appropriate gender of the recipient

8. Provider Contact Person

- Enter the primary contact person for the requesting service or provider

9. Provider Name

- Enter the name of the requesting provider

10. Provider NPI/API Number

- Enter the Provider ID number. A 10 digit number is used for Providers using their National Provider Identifier or Atypical Provider Identifier

11. Provider Address (Including 9 digit Zip code)

- Enter the provider's service address
- **9 Digit Zip Code (Required):** Providers must enter their 9 digit Zip code to ensure that their correct location is identified for the National Provider Identifier (NPI) number

12. Provider Phone Number

- Enter the phone number of the requesting service provider

13. Provider Fax Number

- Enter the fax number of the requesting service provider

14. DSM IV Diagnostic Codes

- Enter the appropriate DSM IV code. ***Axes I and II are required codes***

15. Current Medications

- Enter the name of the current medication, the current dosage, the frequency of the medication, and mark with an **X** if the recipient is compliant on the medications

16. Enrollee Last Name

- Please re-enter the enrollee's last name as it appears on the Medicaid card

17. Enrollee First Name

- Please re-enter the enrollee's first name as it appears on the Medicaid card

18. Enrollee Medicaid Number

- Please re-enter the enrollee's Medicaid number



19. Current Symptoms/Behaviors

- Please follow instructions on front of form

20. Projected Discharge Date

21. Please answer question by marking appropriate choice with an X

22. Please answer question by marking appropriate choice(s) with an X

- Please enter date of the ISP.